

## IF HIPPOCRATES WERE ALIVE\*

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WE in occupational medicine have special problems with confidentiality. The private physician is selected by the patient for the good of the patient. We certainly are not—at least usually—selected by the patient. There is even some question about how we are viewed by the patient. No doubt, many patients regard the occupational physician as a source of help, but a significant number regard us as adversaries. This is a curious patient-physician relation, to say the least. We deal with management, which sometimes wants, demands, or feels they are entitled to more information than we think they are. We deal with unions which tend to view us as adversaries. And many private physicians often think of us as somewhat less than competent, to say nothing about interfering with their practice.

In the days of Hippocrates things had apparently gotten a bit out of hand. Medical practitioners of the time apparently felt a responsibility to do something about it by creating the Hippocratic Oath. This was probably argued over by the ancients for a long time—at least this must be true since we are still at it, as attested by our presence here today! What does the Oath say about confidentiality? The Oath, like the Bible, has gone through several revisions and interpretations. The most recent one I could find was the revision known as the Declaration of Geneva, proposed by the World Medical Association in 1948. It says about confidentiality, “I will hold in confidence all that my patients confide in me.” A simple, hard-nosed statement!

Let us consider the times of Hippocrates. I suspect they were not dissimilar to my early years in a small midwestern farming community nearly 60 years ago. Everyone knew the town drunk—heaven forbid that we would have two or three! And what about the poor person with “fits,”

\*Presented at a *Conference on Ethical Issues in Occupational Medicine* cosponsored by the New York Academy of Medicine and the National Institute for Occupational Safety and Health and held at the Academy June 21 and 22, 1977.

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whom everybody knew could not do certain jobs, and whom everyone compassionately helped when the fit occurred in school, the local grocery store, or wherever! Fortunately, there were no paramedic ambulances to call so we could avoid this little community responsibility. Then there was the poor “odd” person that everyone knew acted “differently” and the unfortunate person everyone knew was playing with about a half a deck. We knew this for several reasons, among them that he or she never made it beyond the third grade in school. You realize, of course, that reading and writing were a requirement for promotion in those far distant days! And when you were fortunate enough to have measles, mumps, or chicken pox you not only could stay home from school, a very large bonus, but you also would have a very large red sign nailed to the door of your home by the local health officer telling the world the cause of your illness and warning it to beware. We did not know much about poliomyelitis in those days. But the signs indicating scarlet fever, typhoid, and tuberculosis struck terror in the local populace, and were apt to cause them to walk on the opposite side of the street.

Transportation was not much of a problem. The largest vehicle was probably a four-seat buggy. Everyone knew that the easiest way to get a drunk home safely was to dump him in the buggy, tie the reins to the seat, turn the horse loose, and the problem was solved. There were very few single horse accidents! The Model T Ford was not much of a problem. One could hardly go fast enough to injure anyone except by running into or, even worse, being hit by a train. The trains! Those huge, hissing, smelly, wonderful means of getting just about anywhere. And everyone knew the engineer was the most clean-living, ethical, affluent man in town. He always put the safety of his passengers and cargo above anything else. And insurance companies—whoever heard of them? What beautiful days! I suppose Hippocrates thought so too and functioned under about the same circumstances.

When it came right down to it, the issues involved were very simple. I would guess the Hippocratic Oath prevented only two things: gossip by his cronies at the local marketplace, and some psychiatric disclosures. Unfortunately, they did not know about psychiatry because Sigmund Freud chose to come along much later. And what about occupational medicine? There probably was very little attention paid to this; hemlock, vapors, and many other unusual things were in vogue. Bernardino Ramazzini was not born until 1633, and since he was the father of occupational medicine, it seems

quite certain that the ancients could give little or no consideration in their oath to this intrusion in medicine. And why should they? As in the little town in the midwest, everyone knew everyone and almost everything about them, their capabilities and how to integrate them into society for the benefit of both the individual and society. Those who could not be integrated were taken care of. After all, isn't this the name of the game?

It remained for us to complicate things. Among other things, urbanization with its anonymity, development of complicated industrial processes, mass transportation, insurance in all forms, and the strong trend for the rights of the individual have changed all this. We even invented the Occupational Safety and Health Act—a legal response to what clearly were neglected moral problems. What I am saying is that in a few short years we have become a highly legalistic society stressing the rights of the individual—often to the detriment of society.

The American Medical Association (AMA) has addressed the issue of confidentiality in its 10-section Principles of Medical Ethics. Section 9 states: "A physician may not reveal the confidence entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community." This says it all in a very neat, concise way. As I view the problems of confidentiality from the view of either a private or an occupational physician, it fits the problems I see.

The AMA issued a booklet *Opinions and Reports of the Judicial Council*, which are interpretations of the Principles of Medical Ethics. Prior to the 1977 booklet there were no opinions about confidentiality. In the newly published current issue there are four opinions. I recommend them to you for your reading. Another comment about these principles: the AMA has moved away from the inflexible view of our ancient friends and recognizes that confidentiality is not absolute—yet another bit of evidence of changes in the structure and demands of modern society.

The American Occupational Medical Association (AOMA) adopted a 12-point Code of Ethical Conduct for Physicians Providing Occupational Medical Services in July 1976 (see Appendix). I would like to clarify our position on this. First, it is not an attempt to rewrite, change, or interfere with the AMA Principles of Medical Ethics. We subscribe to them and solidly stand behind them. The AOMA code was our effort to define the special role of the occupational physician. It was adopted to upgrade the

practice of occupational medicine by providing the moral fiber for a definition of our role. Point seven deals with confidentiality as follows: “[Should] treat as confidential whatever is learned about individuals served, releasing information only when required by law or by overriding public health considerations, or to other physicians at the request of the individual according to traditional medical ethical practice; and should recognize that employers are entitled to counsel about the medical fitness of individuals in relation to work, but are not entitled to diagnoses or details of a specific nature.” Here, too, we see recognized the fact that confidentiality is not absolute. An attempt is made to enhance the interpretation of our role in the industrial setting. It is hoped that the AOMA will also develop a series of judicial opinions originating from questions posed to their newly formed Judicial Committee.

It is important that we understand the definitions of the terms we are using. For instance, there is a difference between privacy and confidential and privileged communication. As I see the problem, we deal with all of these.

I view privacy as the right of an individual to withhold information. The question this raises is how far will society allow the right of privacy to extend?

Confidentiality of information arises when a person chooses, usually voluntarily, to disclose personal information with the expectation that it will not be disseminated to others. The person disclosing information about himself may, explicitly or implicitly, expect this guarantee before disclosing the information.

This, then, leads to the term “privileged communication.” It seems that this is the real issue. Legal definitions probably do not always agree with dictionary definitions. I consulted a very old Webster’s dictionary. Noah Webster, born in 1758 and being somewhat of a pundit himself, probably was not prejudiced by our present state of confusion, in which we seem not to know what we are saying. He defines privacy as: “a private or personal matter; a secret—now rare.” So it seems that the rumblings of our current problems originated farther in the past than Noah Webster.

For confidential communication we find “see privileged communication.” While this does not say much, it seems to distinguish between the level of confidentiality one expects—or hopes for—from a friend and that which is regarded as being legally safe, a big difference.

This leads to privileged communication, which is defined in more

precise terms as “a communication between parties to a confidential relation such that the recipient cannot be legally compelled to disclose it as a witness, as a communication between lawyer and client, physician and patient, husband and wife, etc.—often called a confidential communication.”

If one views the progression of the problems we are discussing from the time when Hippocrates and his friends were trying to prevent gossip in the local marketplace to our present day of not knowing what is right, we can and must draw some conclusions.

I shall use confidentiality as the equivalent of privileged communication. What are the intrusions on this sacred trust? It seems to me they are all increasing demands by several segments of modern society.

First let us take a look at industry. We have become a production-oriented, profit-oriented, highly structured society in the usual urban industrial setting. Managers' performance—all the way to the top—is judged by increasing productivity and profits. Quality is also somewhat important. But we have been somewhat slow in making people important, slow in hiring the handicapped because these employees interfere with productivity and profits. These are new demands that are created in modern times.

What about the insurance industry? Insurance has been a boon—and sometimes a boondoggle! In fact, the insurance industry is not bad. The “superbookie” of our time will quote the odds and take a bet (“premiums” is a more refined term) on anything. I suspect they do take the “dealers edge,” and to do this they must know the facts, which has, at times, resulted in a bit of intrusion into the privacy of unsuspecting individuals. A possible increase in insurance premiums has been used as an excuse by industry as a reason for not hiring, or even for discharging, certain employees who presumably would be at higher risk.

Lawyers, too, have contributed to our dilemma. Through their ability almost indiscriminately to subpoena medical records for that witch-hunting ritual, more politely known as the deposition process, confidentiality is almost totally destroyed. And who would deny that we are living in a more litigious society?

Physicians? Yes indeed, physicians too! Let me confine this to occupational physicians. For many years trust was not common among us—or at least among all of us. Information obtained was put into a pipeline to management, to insurance companies, and to other parties who likely had no right to the information. This, all in the mistaken belief that because the

company paid their salaries it had the right to dictate what physicians should do, to demand total loyalty, and to have access to all the information in the medical file. A sad state of affairs.

The government itself has caused some intrusion by enacting laws "for the good of the individual." For example, workmen's compensation laws require disclosure of information. Or the person being sued in a civil suit has the right of search and disclosure for any relevant information. What does this do to confidentiality?

Last, but certainly not least, is the individual with something to hide—or perhaps nothing to hide. This individual is faced with all of the intrusions discussed. We are now living in a self-oriented, hedonistic society. We have progressed to the point where the rights of the individual in many instances are given priority over the rights of society. Pressures are exerted for privacy and confidentiality. So who tells the truth?

Is it any wonder that we are here discussing these issues today? Enough for the issues. What can or will we do about them? What are the more specific problems facing the occupational physician?

Before we look at these, I would like to define an occupational physician. We may start with the definition of the National Institute for Occupational Safety and Health: "A duly licensed physician who is certified by or is qualified to become certified by the American Board of Preventive Medicine." It defines an industrial physician as "A duly licensed physician who has had specified short postgraduate courses in Occupational Health and Safety and maintains competence in the field by continuing postgraduate educational courses." I shall include them both in the definition of an occupational physician. Truthfully, there are physicians employed by industry who meet neither of these qualifications but still are practicing occupational medicine.

From an occupational physician's point of view, what harm can come to an individual through a violation of privileged communication? There are really only two: limitation of job opportunity and embarrassment from gossip. Further, what is the harm to the industry or society if an individual insists on the right of privacy? Again, in a simple way, we can look at it as just two problems. First would be increased costs to the industry through poor production or through increased insurance premiums. Second would be physical harm to the individual concerned or to others. These would not seem to be insurmountable problems. I shall simply ask some questions to illustrate the complexity of this dilemma.

Was the commercial airline pilot within his rights in demanding privacy and confidentiality when advised by two psychiatrists to discontinue flying until he had been treated for his illness—this after one crash? Later he piloted a craft which crashed, killing all aboard, and the investigation disclosed pilot error as the cause of the crash. What about an epileptic climbing a telephone pole or a paroled rapist given a job which involves entering homes where women are known to be alone? Where does the right of the individual become secondary to the safety of society? The “right to privacy” precludes proper job placement.

What about our staunchly insisting on the alcoholic’s right of confidentiality, and defending this right all the way to the grave? Yet medically we have proved beyond a doubt that the supervisor of the alcoholic employee can be one of the most positive influences in the recovery process if the supervisor knows the diagnosis and becomes part of the rehabilitation process. This is also true for the drug abuser and emotionally ill employee.

What about insurance forms? They are often returned to the supervisor of the employee. Is this confidential? We all know the propensity of people to gossip. We talk about confidentiality of medical records and pay little or no attention to this potential leak of information. Since most physicians realize this, do you for a moment believe that we always obtain accurate diagnoses? Of what value is this data for good epidemiologic studies or in proper job placement?

We all believe as physicians that the history is the most important part of the diagnosis. If you were an executive, were forced to go through the ritual of an annual examination, and knew the results would be transmitted to upper management, what would you do? Would you tell the physician about those strange chest pains you have had recently? If you knew everything that would be disclosed, would you issue a blanket authorization to an insurance company to receive the information in your medical record? Indeed, should occupational physicians respond to these blanket authorizations at all? Might our patients be better off if we simply replied that our record is for occupational purposes only? And how much information does one give to the union representative who wishes to have medical facts? And, even with an authorization, should all medical facts be given to a nonprofessional?

When we are authorized to send medical information to personal physicians, do we also include our suspicion that the patient is an alcoholic, or emotionally ill, or having an extramarital affair? What do we do when we know without doubt that the patient is receiving improper or inadequate

care? One could go on with perplexing hypothetical questions. I have posed these few simply to illustrate the complexity of the problem.

Now what about the solutions? When all of industry recognizes and acts out that each individual in society has a right to lead the most fulfilling life possible within his own limitations, including employment, we shall have come a long way. The handicapped will then no longer need to lie to be employed. Employment will not be capriciously terminated. Each individual will be given a sense of self-achievement and self-worth.

What about occupational physicians? First, they must practice according to the principles of the AMA and the code of the AOMA. They must practice in a nonadversary manner, utilizing the knowledge possessed to assure the proper placement, health, and safety of the individual involved. If this is done with full information and with diligence the safety of society will be assured.

What about laws? The Boston Tea Party—a major riot of its time—did not erase the unfair law of taxation without representation. So laws must be fair—no small task! We seem to have failed to learn from the Volstead Act passed in 1919 that morality and health cannot be legislated.

For lawyers I would simply say “Seek the truth.” For unions I would say “Look to the future for honest solutions.” If the individual could be assured that all others concerned would act in the way described, then society could demand the disclosure of private information which may harm society and could inflict penalties for nondisclosure of this information.

When all is said and done, it seems that the far-distant true answer to these problems will come when moral individuals of good judgment seek and execute honest answers. In the meantime, it seems we are doomed to grope through a morass of laws, agency rulings, grievances, suits, and various other jousting procedures. In fact, our society seems to prefer this solution. Russell Baker, in *The New York Times Magazine*, says, “If all students now dreaming of law school manage to get in, the country will suffer a plague of lawyers by 1984. We already have at least 10 times as many lawyers as any rational society can tolerate, which doubtless accounts for the triumph of irrationality in American life. Unless something is done to keep this present batch of students out of Blackstone, the nation will probably expire of terminal jurisprudence before the turn of the century.”

Take heed—the time for rational action is now! If Hippocrates were alive today he very likely would utter a short, succinct, pithy oath!